MO HealthNet Division (MHD) October 13, 2011 Health Home Conference Call Highlights

Frequently Asked Questions (FAQs) from this call will soon be available at this same website.

Health Home Overview

Current Initiatives

- There are two health home initiatives underway – one for Primary Care and one for Behavioral Health through Community Mental Health Centers (CMHC).
- Both initiatives must be reviewed and approved by the Centers for Medicare and Medicaid Services (CMS) through the state plan amendment (SPA) process. A SPA is the agency's written plan regarding Missouri's approach to the Health Home program . Revisions may be required by CMS.

State Plan Amendment (SPA) Approval Process

- The Behavioral Health SPA has been approved by CMS. The SPA is available on the Department of Mental Health (DMH) website for your review at http://dmh.mo.gov/docs/medicaldirector/MOSPA11-1110-21-11.pdf.
- MHD and partners are in the process of revising the Primary Care SPA, with the goal to submitting the application in early November, 2011. We anticipate approval of the Primary Care SPA by December 2011, with services beginning in early February 2012.
- CMS is currently requiring additional discussions regarding the payment methodology for the Health Home program. As stated in the application, we originally proposed three payment forms- a start up payment, a PMPM, and a shared savings.
  - CMS did not approve the start up payment model and is in favor of rolling that up into the PMPM.
  - Also, discussions are taking place around the PMPM and the shared savings models. The details of the shared savings methodology will take longer to work out and may be completed after the program is underway.

Health Home Core Components

- Staffing model
  - The staffing model was developed with substantial input from our stakeholders through numerous meetings, site visits, and ongoing input from state partners

- Stakeholders include the providers selected to participate in the Health Home program, The Missouri Foundation for Health, (MFH) The Health Care Foundation of Greater Kansas City, and The Missouri Hospital Association (MHA).
- State partners include MO HealthNet Division (MHD) and the Department of Mental Health (DMH).

- The model includes the following staff positions and duties:
  - Health Home Director: Individual shall provide leadership, be a Health Home champion, design prevention and wellness initiatives, develop and maintain a working relationship with specialty providers and hospitals, and oversee quality improvement efforts. This individual need not be a physician. Staff ratio is 1/2,500.
  - Health Home Coordinator: Individual shall provide administrative support; referral tracking, training for other staff on the Health Home program; technical assistance, data collection and reporting to support performance improvement (PI); and medical records as needed for care coordination. Staff ratio is 1/750.
  - Nurse Care Manager: Individual shall provide health education to patients, develop the patient's treatment plan, and assist with the patient's wellness goals. Staff ratio is 1/250.
  - Behavioral Health Consultant: Individual shall serve as the liaison with the patient's mental health provider by assisting with access and collaboration between the patient's primary care and mental health providers; screen and evaluate the patients for mental health disorders; provide brief patient interventions; integrate behavioral health needs with the patient's primary care needs; assess the impact of the patient's mental health issues on his/her primary care needs. Staff ratio is 1/750.

- Sites
  - Currently enrollment is being determined at the organization level, although most applications included more than one site per organization. All organizations approved to be Health Home providers will remain in the Health Home program unless the organization itself and/or any of its sites chooses to no longer participate. For example, an organization may apply for seven sites, but only three sites elect to enroll in the Health Home program.
    - This determination is based on MHD data analyses in conjunction with our stakeholder partners.
    - The data takes into consideration the available budget as well as available information for each organization's MO HealthNet participant volume.
- Payment structure
  - As mentioned above, CMS did not approve the start up payment in the CMHC SPA. The decisions made for the CMHC PMPM model will determine the structure for the Primary Care PMPM model.
  - Shared savings model is under discussion with CMS on the CMHC side. DMH may need to resubmit this model as an amendment to the Behavioral Health SPA.

- The Primary Care PMPM target payment is $58.87, with an expectation that $3.47 will go towards external administrative costs and data analytics. The net PMPM to the organization will be $55.40. The total PMPM includes $2.40 to cover physician attendance at Learning Collaborative training.
- Remember that the PMPM is only for assigned Health Home patients and is in addition to current payments received from MHD or Managed Care. The PMPM is for those patients that meet the enrollment criteria which includes both fee-for-service (FFS) and Managed Care patients.
- MHD should be able to give a projection of number of potential eligible patients by early November when we are finished completing data runs.
- Remember that we have a global budget within which to work. If the total number of patients exceeds the budget, we will need to determine the best methodology to stay within budget constraints.

- Budget categories
  - We have different types of clinics approved to be Health Home providers - Federally Qualified Health Clinics (FQHC), Rural Health Clinics (RHC) and hospital based clinics
  - The different types of organizations have different budgeting categories which will involve collaboration between MHD, MPCA, and MHA. There will be variations in how those payments flow.
  - The Federal Medical Assistance Percentage (FMAP) for the Health Home program: Feds will pay 90% of funding requirement for eight (8) quarters, with the 10% funding match being calculated differently depending on the Organization Type.
  - MHD will set up a future call with those in the Intergovernmental Transfer (IGT) group to discuss the logistics further.

Learning Collaborative Update

- The health home and learning collaborative initiatives are possible due to the collaboration between the MHD, DMH, the Missouri Foundation for Health (MFH), the Health Care Foundation of Greater Kansas City, and the Missouri Hospital Association (MHA).
- Marge Houy with the Bailit Group (MHD contractor for this project providing technical assistance to the State) provided the following update
  - The Health Home program is sponsored by the Missouri Foundation for Health, the Missouri Hospital Association, and the Health Foundation of Greater Kansas City
  - Train the Trainer Model: a pilot site willbe selected from each region, along with a trainer, and will be responsible for training the other sites.
  - The collaborative will need a balance of practice sites and numbers.
  - There will be a “Welcome Call” on October 25.

- The Curriculum Development workgroup has met twice and is resolving the curriculum in upcoming meetings, serving as a sounding board for input received from the providers.
- Letters are being sent to provide a calendar specifying the amount of time involved in the training.
- The Global Budget for the Collaboration is over $1M. This would otherwise have come from admin costs, reducing the net PMPM received.

Proposed Job Descriptions and PMPM for Primary Care Health Homes

Nurse Care Manager	1 FTE/250 enrollees $105,000 / year	PMPM $35.00	a. Develop wellness & prevention initiatives b. Facilitate health education groups c. Participate in the initial treatment plan development for all of their Health Home enrollees d. Assist in developing treatment plan health care goals for individuals with co-occurring chronic diseases e. Consult with Community Support Staff about identified health conditions f. Assist in contacting medical providers & hospitals for admission/discharge g. Provide training on medical diseases, treatments & medications h. Track required assessments and screenings i. Assist in implementing MHD health technology programs & initiatives (i.e., CyberAccess, metabolic screening) j. Monitor HIT tools & reports for treatment k. Medication alerts & hospital admissions/discharges l. Monitor & report performance measures & outcomes
Behavioral Health Consultant	1 FTE/750 enrollees $70,000/year	PMPM $7.78	a) screening/evaluation of individuals for mental health and substance abuse disorders b) brief interventions for individuals with behavioral health problems c) behavioral supports to assist individuals in improving health status and managing chronic illnesses d) The behavioral health consultant both meets regularly with the primary care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal “curbside “ manner as part of the daily routine of the clinic

			e) Integration with Primary Care o Support to Primary Care physician/teams in identifying and behaviorally intervening with patients who could benefit from behavioral intervention. o Part of front line interventions with first looking to manage behavioral health needs within the primary care practice. o Focus on managing a population of patients versus specialty care f) Intervention o Identification of the problem behavior, discuss impact, decide what to change o Specific and goal directed interventions o Use monitoring forms o Use behavioral health "prescription" o Multiple interventions simultaneously g) Education o Handouts o "Teach back" strategy o Tailored to specific issue h) Feedback to PCP o Clear, concise, BRIEF o Focused on referral question o Description of action plan o Plan for follow-up
Health Home Director Administrative support	1 FTE/2500 enrollees $90,000 / year Non-PMPM paid staff training time Contracted services	PMPM $8.87	a. Provides leadership to the implementation and coordination of Healthcare Home activities b. Champions practice transformation based on Healthcare Home principles c. Develops and maintains working relationships with primary and specialty care providers including inpatient facilities d. Monitors Healthcare Home performance and leads improvement efforts a. Designs and develops prevention and wellness initiatives Referral tracking b. Training and technical assistance c. Data management and reporting d. Non-PMPM paid staff training time

Care Coordination	1 FTE/750 enrollees $65,000/year	PMPM $7.22	e. Referral tracking f. Training and technical assistance g. Data management and reporting (can be separated into second part time function) h. Scheduling for Health Home Team and enrollees i. Chart audits for compliance j. Reminding enrollees regarding keeping appointments, filling prescriptions, etc. k. Requesting and sending Medical Records for care coordination
TOTAL PMPM		**$58.87**	